## Superior Vision Our Members. Our Mission.

## **VISION INSURANCE**

## **Underwritten by National Guardian Life Insurance Company**

Administered by: Superior Vision Services 11101 White Rock Road, Suite 150 Rancho Cordova, CA 95670



## Enrollment / Change Form

GROUP EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)    City of Emporis	Please print and complete all sections.											
Group Name  City of Emporia  A Sec   Last Name   First Name   M.I. Date of Birth   Social Security Number    Email Address   City/State/Zip   Home Phone   ( )    Email Address   City/State/Zip   Home Phone   ( )    Employee   Employee + Emplo	GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change						change of name or coverage)					
A Sex   Last Name   First Name   M.L.   Date of Birth   Social Security Number   Work Phone   ( )	Group Na	ame			Group Number	Location	Location		Effective Date		Date of 1	ine
A   Sex   Last Name (dependent)   First Name   M.L.   Date of Birth   C   Bi	City of Emporia				31319	0.14.0017.1				Ta		
Employee   Employee + Employee + Employee + Employee + Child(ren)   Family   Waive due to other coverage      FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll)   T: Terminate   C: Change (change of name or coverage)	T	☐ M	Last Name									
Employee   Employee + Child(ren)   Employee + Child(ren)   Family   Other coverage   Waive of the coverage					e/Zip Hon			e Phone			Work Phone	
Employee   Employee + Child(ren)   Employee + Child(ren)   Family   Other coverage   Waive of the coverage							(	)		(		
Employee Only Spouse Employee + Employee + Child(ren) Employee + Family Waived due to other coverage	Email Address								Co	ell Ph	one )	
Employee Spouse Children Family other coverage    Children   Family   Other coverage	ELECTION(S)											
FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)    A   Sex											1	Waive
A   Sex   Last Name (dependent)   First Name   M.I.   Date of Birth   Child unmarried and full-time student or handicapped?   Yes   No												
□ A Sex   Company       Last Name (dependent)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?	FAMIL	Y INFORM	IATION (Only those elig	ible may be	e enrolled.) A: Ac	dd (enroll) T:	Termi	nate	C: Change (chan	ige of	f name or	coverage)
A   Sex	□ A □ T	Sex M	Last Name (spouse)		First Name		M.I.		Date of Birth			
T	□ A □ T	Sex	Last Name (dependent)		First Name		M.I.		Date of Birth		full-time s handicapp	tudent or oed?
A   Sex   Last Name (dependent)   First Name   M.I.   Date of Birth   Yes   No	T	M	Last Name (dependent)		First Name		M.I.		Date of Birth		□Yes	□No
A   Sex   Last Name (dependent)   First Name   M.I.   Date of Birth   Yes   No	□ A □ T	Sex M	Last Name (dependent)		First Name		M.I.		Date of Birth		□Yes	□No
A   Sex	A T	Sex M	Last Name (dependent)		First Name		M.I.		Date of Birth		□Yes	□No
A   Sex	A T	Sex M	Last Name (dependent)		First Name		M.I.		Date of Birth		□Yes	□No
Do you or any of your dependents have other vision insurance?	A T	Sex M	Last Name (dependent)		First Name		M.I.		Date of Birth		□Yes	□No
Employee Signature.	If yes, please give: Policyholder and Insurance Company											

**Fraud Warning Statement:** Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of committing a fraudulent insurance act.